Put Your Money Where Your Advice Is

TO THE EDITOR: As a physician, I observe the debilitating effects of tobacco and alcohol products in my patients on a daily basis. Because I give each of them my encouragement and advice in ending their addiction, I feel it would be hypocritical if my personal financial portfolio included investments in companies directly involved in the manufacture and marketing of these products. As a professor of medicine at a university medical center, I also realize that my example can encourage young health professionals to consider excluding these products from their own investments.

My university has enlisted several companies to assist them in investing for a campus-wide retirement organization. Recently this organization solicited participation by university personnel in an election for a representative to its advisory board. A total of 13 well-qualified candidates were proposed, and their biographical statements were widely distributed to the electorate. To determine each candidate's position regarding divestiture, or at least to the extent they would advise limiting the university's investments in tobacco and alcohol products, I contacted each candidate and asked the following question: "Would you divest or seek to limit the University Retirement System's investments in tobacco and/or alcohol products?" Of the 13 candidates, 10 responded.

Against Divesting	Ambivalent	For Divesting	No Commitment
1	3	5	1

I voted for the candidate I considered the best qualified and who favored divestiture. The winner was one of the five candidates for divesting.

Questioning the investment policies of those institutions to which we belong—for example, schools and medical societies—is an underused tactic for avoiding support of tobacco and alcohol companies.

JOSEPH A. ABBOTT, MD
1870 Jackson St, #502
San Francisco, CA 94109

Let's Not Do With Euthanasia What We Did With Abortion

TO THE EDITOR: It looks as though it is coming—amid protest, fear, and warnings of Nazi-like death camps. But it is so logical, so economical, and so merciful in many cases that it appears inevitable. This fearful yet desirable apparition is, of course, euthanasia, and it is becoming the subject of hot debate.*

In The Netherlands both assisted suicide and active euthanasia are commonplace since sympathetic courts will not prosecute. In the United States, there is a growing sympathy for those suffering from painful and hopeless conditions, and we are now beginning to accept passive euthanasia to a greater extent. We aren't ready for active euthanasia yet, and the majority of doctors here still decry assisted suicide. It seems in 1992 that all this is unacceptable and remote and that it won't come to America, at least not in our lifetimes.

Let's not be too sure about that. Popular opinion has made 180-degree turns, and even our own conservative medical profession has reversed itself dramatically in our time. Before the famous *Rowe versus Wade* decision by the Supreme Court and before some states had liberalized abortion laws, the image of a physician who did abortions for anything other than to save a mother's life, or at least her health, was on a par with that of a drug dealer today. There certainly has been an almost complete reversal in our attitudes now that abortion on demand is legal. So could our rejection of active euthanasia take a similar turn.

Though I have mixed thoughts about euthanasia, I fear that, as we now have more than a million abortions each year, we could end up having millions of the sick and elderly being put to sleep. There will be all sorts of pressures to expand the indications beyond pain and misery and hopelessness. These pressures could include deficits in national and state budgets, a continued rise in health costs, overcrowding due to excess population, environmental concerns, limited resources clashing with unlimited demand, housing shortages, and more.

There is another pressure that I fear even more—that euthanasia may become a profitable specialty. Were a death well paid for, and it certainly could be, would we not see a rising number of physicians seeking to profit by it? Good pay encouraged many life-conscious obstetricians to take up abortion, and the profitability of selling one's expertise or persuasiveness in the courtroom has created a new specialty, "the hired gun." Imagine these new thanatology specialists, with their own societies and associations and their own medical journals, devoting their practices to what some altruistic doctors have always done for free. Do we want a new professional class of medical killers, and what would their true motives be, compassion or money?

There are many of us who have eased patients along with drugs, realizing we were hastening death, but we have done it out of pure compassion. We have not demanded a fee for this. This is the way it should be if euthanasia becomes legal, as I believe it must someday.

Let us insist that whosoever has a patient so in need of euthanasia that compassion screams for it, that person be compassionate enough to do it for free. This will eliminate the commercial aspects, will parry criticism, will avoid all conflict of interest, and will be truly humanitarian. I see a real danger to our society if we do not.

GEORGE B. MARKLE IV, MD
1003 N Shore Dr
Carlsbad, NM 88220

*See "Physician Aid in Dying—What Physicians Say, What Patients Say," F. J. Girsh, EdD; and the Editorial Comments by P. K. Longmore, PhD, C. K. Cassel, MD, A. R. Jonsen, PhD, and F. Fitzgerald, MD, in the August 1992 issue of THE WESTERN JOURNAL OF MEDICINE (Vol 157, pp 188-194).